



King County

Community Services Division

Department of Community and Human Services

401 5th Avenue, Suite 510

Seattle, WA 98104

206.263.9062 FAX: 206.296.0156

TTY RELAY: 711

IMPLEMENTATION PLAN

2012 – 2017 Veterans and Human Services Levy

Activity 2.1.C Outreach and Engagement, Mobile Medical Outreach

1. Goal

Prevent and reduce homelessness.

2. Strategy

The Veterans and Human Services Levy Service Improvement Plan (SIP) set a goal of ending homelessness through outreach, prevention, permanent supportive housing and employment.

3. Activity 2.1.C Outreach and Engagement, Mobile Medical Outreach

Activity 2.1.C Mobile Medical Outreach described below is one of four activities funded under Activity 2.1: Outreach and engagement.

4. Service Needs, Populations to be Served, and Promotion of Equity and Social Justice

a) Service Needs

South King County Response to Homelessness: A Call for Action (2008) cites national research that identifies lack of affordable health care as one the principal causes of homelessness in the U.S. This report also documents that chronically homeless people surveyed at South King County food banks as part of the 2007 One Night Count reported “a host of medical and psychiatric problems for which there are few local access points for those without health insurance or substantial income.” Many reported “trauma and recent ill health; medical problems (heart attack, cancer, surgeries); asthma, diabetes; trauma from violence on the street; dental problems, migraines, skin problems, depression; loss of parent or spouse,” [and] “22 percent had received treatment for mental health problems in past 3 years.”

Data collected in needs assessment screenings administered at intake to all Mobile Medical Program clients served since 2008 show that the issues documented during the 2007 One Night Count survey are commonplace among our target population. The majority of clients fit into at least one of the following five groups that national studies have shown are the most likely to fall through community safety nets¹:

¹ McMurray-Avila, Marsha. Organizing Health Services for Homeless People, 2001.

- People with severe mental disorders
- Women who are the victims of domestic violence or with a long history of abuse
- People with substance abuse problems and no resources to afford treatment
- Veterans with physical or mental disabilities
- People with chronic physical problems or disabilities that prevent them from working.

Needs data collected in the first year of program operation, for example, showed that 76 percent of new medical van patients perceived that they have unmet primary care needs and 63 percent perceived that they have unmet dental care needs.

b) Populations to be Served

This program prioritizes single adults in targeted areas of South King County who are chronically homeless. This is one of the primary target populations of the Veterans-Human Services Levy. We base our definition of the South King County sub-region on school districts. South King County is defined as the areas encompassed by the following school districts: Enumclaw, Tahoma, Auburn, Federal Way, Highline, Kent, Renton Tukwila and Vashon. The target population includes both men and women, although the majority are men. Many have severe mental illness and substance abuse issues; most will have significant physical health problems. Some have Post-Traumatic Stress Disorder, and many are veterans.

c) Promotion of Equity and Social Justice

The Equity and Social Justice Ordinance requires King County to consider the impacts of its policies and activities on its efforts to achieve fairness and opportunity for all people, particularly for people of color, low-income communities and people with limited English proficiency. The King County Equity Impact Review Tool available online at: <http://www.kingcounty.gov/exec/equity/toolsandresources.aspx> provides a list of the determinants of equity that may be affected by your activity. Evaluate your activity's impact by responding to the following questions:

i) Will your activity have an impact on equity?

Yes. The Mobile Medical Program provides health and human services that are high quality, affordable and culturally appropriate and support the optimal well-being of all people.

ii) What population groups are likely to be affected by the proposal? How will communities of color, low-income communities or limited English proficiency communities be impacted?

The program's target population of chronically homeless people is overwhelmingly low-income. For example, in 2011, 97 percent of Mobile Medical Program clients were below 30 percent of the median income level for King County. Numerous research studies have indicated that homeless and low income populations have much more limited access to primary medical care, mental health services, and

dental care than the general population. It is also important to note that people of color are overrepresented in the homeless population of King County and that the program's clients represent a racially diverse group. The program focusses its resources on expanding access to all needed health services for this vulnerable special population.

- iii) What actions will be taken to enhance likely positive impacts on these communities and mitigate possible negative impacts?

The program will continue to expand and improve its case management and navigation assistance for low-income homeless people to ensure that those without ready access to needed health care services are effectively linked to ongoing care. There have been no potential negative impacts identified.

5. Activity Description

The Mobile Medical Program, which is operated directly by Public Health-Seattle and King County, links people experiencing homelessness to primary and specialty health care, mental health and chemical dependency treatment, housing assistance, and various social services. The program achieves these linkages by integrating intensive outreach with medical care, dental care, clinical needs assessment, navigation, and close case management. The purpose of this work is to help clients achieve greater stability in terms of their health, housing, and self-sufficiency.

Late in 2012 the program received one-time additional funding in the amount of \$375,000 to purchase a new mobile medical unit. The new unit will significantly increase the program's clinical treatment space and will greatly improve the efficiency of service delivery.

6. Funds Available

The 2012 allocations for this activity are provided in the table below.

	2012	2013	2014	2015	2016	2017
Veterans Levy	\$ 205,000	\$ 90,000	\$ 90,000	\$ 90,000	\$ 90,000	\$ 90,000
Human Services Levy	\$470,000	\$210,000	\$210,000	\$210,000	\$210,000	\$210,000
Total	\$675,000	\$300,000	\$300,000	\$300,000	\$300,000	\$300,000

In 2012 an original allocation of \$ 300,000 (\$90,000 Veterans Levy and \$210,000 Human Services Levy) was provided. The 2012 Supplemental Budget Ordinance included additional funding of \$375,000 consisting of \$115,000 in Veterans Levy funds and \$260,000 in Human Services Levy funding, for the purchase of a new mobile medical unit. With the supplemental funds the total funding available in 2012 was \$675,000. Additional funds will be available annually through 2017 to implement this activity based on performance.

7. Evidence-based or Promising Practices

In a 2007 national review of mobile health care for homeless people, mobile medical is described as part of a continuum of outreach services: "The use of mobile clinics to reduce financial, geographic, and psychological barriers to health care for people who are homeless

is distinctive yet complementary to other outreach methods, such as “street medicine” provided by walking teams.” The report notes that mobile programs can improve access to care by providing “compassionate, culturally competent outreach; help with transportation to clinics and other incentives to promote engagement in a therapeutic relationship (food vouchers, hygiene kits clothing); a consistent mobile service schedule, and assistance in applying for public benefits including health insurance.”²

The Mobile Medical Program incorporates best practices related to outreach recommended by the National Health Care for the Homeless Council (nhchc.org). These practices acknowledge that homeless people, especially those experiencing serious disabling conditions and/or long term homelessness, often have difficulty finding or accepting the services and care they need. This may be related to fear, lack of awareness, ambivalence, loss of hope, or any other number of personal reasons. Too often, services are difficult to access because of significant barriers presented by the system itself. Outreach workers attempt to mediate and overcome these psychological, informational and systemic barriers to care. They offer an entryway to services and safety, providing a bridge between the streets and a more stable life.

8. Service Partnerships

Describe any activity partners, co-funders, referral sources, etc. relevant to your activity. Include a description of how the program will coordinate with other similar programs or operate within a larger service system.

Public Health-Seattle and King County contracts with HealthPoint in providing its services. In holding mobile medical and dental clinics, Public Health physicians, dentists, and nurses work hand-in-hand with HealthPoint psychiatric social workers and medical benefits specialists. These HealthPoint employees conduct detailed assessments of program clients with identified unmet needs for primary and/or specialty health care, mental health treatment, chemical dependency treatment, medical benefits, and housing. They then work in a case management mode and in partnership with the program's Public Health nurse to help clients navigate the way to services. In a great many cases, they establish and document a successful linkage to ongoing primary and/or behavioral health care with HealthPoint providers working at HealthPoint clinic sites nearby the meal programs at which mobile medical and dental clinics are held.

The program and its outreach and case management team members also collaborate extensively with King County's Client Care Coordination Program and various housing providers throughout the county in linking program clients who score high on vulnerability screenings to Housing First slots. Specifically, program team members administer the vulnerability screening tool established by the Client Care Coordination (CCC) Program and assist clients who score above the established threshold to apply for CCC housing units.

Other community agencies with which Mobile Medical Program team members regularly collaborate include the Washington Department of Health and Social Services, shelter and transitional housing providers, homeless youth outreach providers, mental health outreach providers, and the programs that operate the community meal programs that host mobile clinics.

² Mobile Health Care for Homeless People: Using Vehicles to Extend Care, Patricia Post, May 2007. National Health Care for the Homeless Council.

The program contracts with Medical Teams International (MTI) in order to provide mobile dental clinics alongside the program's mobile medical clinics several times each month. For each dental clinic, MTI provides its fully-equipped mobile dental units, dental supplies, and a dental assistant; Public Health provides a dentist and outreach worker who coordinates care between the medical and dental clinics.

In addition to the Veterans and Human Services Levy, the federal Health Resources and Services Administration (HRSA) provides substantial funding for the operation of the Mobile Medical Program. Public Health's Health Care for the Homeless Network (HCHN) administers HRSA grant funds as well as other federal grant dollars that support the program. Other funders include the Cities of Auburn, Federal Way, and Kent, each of which provides funds to support mobile dental care.

9. Performance Measures

The following performance measures were identified by the Levy's Evaluation Team.

Objectives	Service Outputs/ Measures	Most Recent Performance	2012 Target(s)	Data Source
Engagement/ Assessment	<ul style="list-style-type: none"> • Clients receiving services through the mobile medical van • Total visits for medical care or psychiatric social worker • Referrals for assistance • Clients linked to MH treatment 	479	479	Report Card – Services
		1,249	1,249	Report Card – Services
		40% of those assessed	40% of those screened	Report Card – Services
		40% of those assessed	40% of those assessed	Report Card – Services
Treatment/ Intervention	<ul style="list-style-type: none"> • Clients linked to medical benefits such as Medicaid, ADATSA, or other 	40% of clients assisted by medical case manager	40% of clients assisted by medical benefits case manager	Report Card – Outcomes